	T	1	1	T	1	1	T.	1
RUN DATE:			TDDC	CHECKWRITE SUMMARY REPORT				
RUN DATE:	10/22/200/			CHECKWRITE SUMMARY REPORT CKWRITE DATE: 10/23/2007				
				FINANCIAL PAYER: NCDMH				
PROVIDER		HIGH DENIAL	NUMBER OF		mia	momar	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	CLAIMS FINALIZED	CLAIMS PAID
3404901	SMOKY MOUNTAINM	8535	1	SERVICE FACILITY LOCATION WAS				
	H/DD/SAS			NOT SUBMITTED ON THIS CLAIM. PLEASE RESUBMIT THE CLAIM WITH				
				The state of the s				
		0	0		0	1	1	0
3404904		143	37	CLIENT ID NUMBER NOT ON STATE				
3404904	WESTERN HIGHLAN DS LME	143	37	ELIGIBILITY FILE				
	DO EME							
		8800	28	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON	0	193	3644	3451
				FUTURE RA'S.				
		21	26	DUPLICATE OF CLAIM-SYSTEM				
		-						
3404910	PATHWAYS	8599	38	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		E200	24	PRIOR AUTHORIZED UNITS EXCEEDE				
		5308	34	PRIOR AUTHORIZED UNITS EXCEEDE D	0	170	3979	3809
		11	33	CLIENT NOT ELIGIBLE ON SERVICE DATE				
				DATE				
3404912	CATAWBA COUNTYM	8599	270	DETAIL NOT COVERED BY COMBINAT				
	ENTAL HEALT			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		24	13	PROCEDURE CODE, PROCEDURE/MODI	0	305	4217	3912
				FIER COMBINATION OR PROCEDURE		303	721/	3912
				CODE/TYPE OF SERVICE COMBINATI				
		3746	11	RELATED CODES NOT ALLOWED SAME				
		3740	11	DATE OF SERVICE.				
3404913	MECKLENBURG COM	8505	7744	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
	ENTAL HEALT			NI BUDGEI				
		8800	925	FURTHER PROCESSING NECESSARY,	0	8893	9074	181
				PLEASE CHECK FOR CLAIM ON				
				FUTURE RA'S.				
		79	76	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
3404916		8505	254	CLAIM DENIED DUE TO INSUFFICIE				
3404916	CROSSROADS BEHA			NT BUDGET				
	VIORAL HEAL							
		8800	95	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON	0	509	2942	2433
				PLEASE CHECK FOR CLAIM ON FUTURE RA'S.				
		24	90	PROCEDURE CODE, PROCEDURE/MODI				
				FIER COMBINATION OR PROCEDURE				
				CODE/TYPE OF SERVICE COMBINATI				
3404917	CENTERPOINT HUM	8534	265	SERVICE FACILITY LOCATION IS N				
3404917	AN SERVICES			OT A VALID IPRS ATTENDING				
				PROVIDER. PLEASE VERIFY THE F				
		11	104	THE PART OF THE PA				
		11	194	CLIENT NOT ELIGIBLE ON SERVICE DATE	1	730	2832	2102
		+						
		24	72	PROCEDURE CODE, PROCEDURE/MODI				
				FIER COMBINATION OR PROCEDURE CODE/TYPE OF SERVICE COMBINATI				
				CODE, TIPE OF SERVICE COMBINATI				
	1	1	1	<u>L</u>	l	1		1

3404919 GUII TAL	ROVIDER NAME (LEFORD CO MEN LEALTHC	HIGH DENIAL EOBS		DESCRIPTION CLAIM DENIED DUE TO INSUFFICIE	TNC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
NUMBER PRO 3404919 GUII TAL 3404919 ALAN 3404920 ALAN	ROVIDER NAME (LEFORD CO MEN LEALTHC	EOBS 8505	DENIALS 566					
3404919 GUII TAL	LIFORD CO MEN	8505	566		DENTERD	PURITALLO	TAUDITED	EUTD
TAL TAL 3404920 ALA)	L HEALTHC			CLAIM DENIED DUE TO INSUPPLICIE				
TAL 3404920 ALAN	HEALTHC	11		CERTIFIC DESCRIPTION TO TROUT TOTAL				
111111		11		NT BUDGET				
111111		11						
111111			73	CLIENT NOT ELIGIBLE ON SERVICE				
111111		11	7.5	DATE	0	691	706	15
111111								
111111								
111111		8800	30	FURTHER PROCESSING NECESSARY,				
111111				PLEASE CHECK FOR CLAIM ON				
111111				FUTURE RA'S.				
111111		8526	2529	CLAIM DENIED, UNITS BILLED MUS				
L AI	AMANCE CASWEL AREA MH D	0320		T BE GREATER THAN ZERO				
	AREA MH D							
		24		PROCEDURE CODE, PROCEDURE/MODI	0	2606	2607	1
				FIER COMBINATION OR PROCEDURE				
				CODE/TYPE OF SERVICE COMBINATI				
		11	25	CLIENT NOT ELIGIBLE ON SERVICE				
			23	DATE				
3404921 ORAN	ANGE PERSON C	120	57	CLIENT ID NUMBER MISSING OR IN				
	THAM AREA			VALID. ENTER CID AND SUBMIT				
				AS A NEW CLAIM				
		11	56	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE	1	341	4886	4545
		8535	56	SERVICE FACILITY LOCATION WAS				
				NOT SUBMITTED ON THIS CLAIM.				
				PLEASE RESUBMIT THE CLAIM WITH				
3404922		21	1092	DUPLICATE OF CLAIM-SYSTEM				
THE ER	DOMINI CENT	21	1032	DOFFICER OF CHAIM-SISTEM				
ER.								
		8800		FURTHER PROCESSING NECESSARY,	41	1677	7010	5333
				PLEASE CHECK FOR CLAIM ON				
				FUTURE RA'S.				
		8935	41	ASTNC INELIGIBLE TO RECEIVE SE				
		0333		RVICES IN IPRS.				
3404923 FIVE	/E COUNTY MH	8505		CLAIM DENIED DUE TO INSUFFICIE				
				NT BUDGET				
		11	65	CLIENT NOT ELIGIBLE ON SERVICE				
		11	03	DATE	0	1577	1754	177
		8800		FURTHER PROCESSING NECESSARY,				
				PLEASE CHECK FOR CLAIM ON				
				FUTURE RA'S.				
3404925 SANI		8505	3923	CLAIM DENIED DUE TO INSUFFICIE				
Oran	IDIII DDD CDIVID			NT BUDGET				
R FC	FOR MH/DD							
		8800		FURTHER PROCESSING NECESSARY,	18	4628	4767	139
	-			PLEASE CHECK FOR CLAIM ON			_	
				FUTURE RA'S.				
 		8599	148	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404926 SOUT	JTHEASTERN RE	23	71	SERVICE REQUIRES PRIOR APPROVA				
	MENTAL HL			L				
		11	60	OF TENER WORD BY LOTTER ON CONTINUE				
		11	60	CLIENT NOT ELIGIBLE ON SERVICE DATE	0	369	5659	5290
		8537	52	PROCEDURE IS NOT PAYABLE FOR Y				
				OUR PROVIDER TYPE AND				
				SPECIALTY IN ACCORDANCE TO MEN				

1	T	1	T		ı	T	Г	
PROVIDER		HIGH DENIAL	NUMBER OF		mara	momar	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	TNC	TOTAL DENIALS	CLAIMS FINALIZED	CLAIMS PAID
	THOUSE HEED				Danting	DINTILLO	THEFTE	111111
3404927	CUMBERLAND CO M	11	222	CLIENT NOT ELIGIBLE ON SERVICE				
	HC			DATE				
		21	106	DUPLICATE OF CLAIM-SYSTEM				
		21	106	DUPLICALE OF CLAIM-SISIEM	0	432	1771	1339
		8599	35	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404930		11	26	CLIENT NOT ELIGIBLE ON SERVICE				
3404930	JOHNSTON COUNTY	11	20	DATE				
	MNTL HLTHC							
		191	1	CLIENT ID NUMBER DOES NOT MATC	0	28	34	6
				H PATIENT NAME				
		0500		DESCRIPTION OF COMPANY				
		8599	-	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404931	WAKE CO HUM SVC	21	858	DUPLICATE OF CLAIM-SYSTEM				
	BILLING OF							
		8599	397	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	97	1833	11332	9499
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		8621	102	60 RESIDENTIAL LEVEL III TREAT				
				MENT RECEIVED, PA IS REQUIRED				
				FOR ADDITIONAL SERVICE.				
3404933	SOUTHEASTERN CT	79	1159	THIS SERVICE IS NOT PAYABLE TO				
	R FOR MH/DD			YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
		8599	234	DETAIL NOT COVERED BY COMBINAT		1000		
				ION OF RECIPIENT, PROVIDER AND	0	1738	3247	1509
 				BENEFIT PACKAGE.				
		8537	153	PROCEDURE IS NOT PAYABLE FOR Y				
				OUR PROVIDER TYPE AND				
				SPECIALTY IN ACCORDANCE TO MEN				
3404934		8505	224	CLAIM DENIED DUE TO INSUFFICIE				
3101331	ONSLOW CARTERET BEHAV HEAL	0303	22.	NT BUDGET				
	BERAV REAL							
		8599	129	DETAIL NOT COVERED BY COMBINAT	0	745	1692	947
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8535	98	SERVICE FACILITY LOCATION WAS				
				NOT SUBMITTED ON THIS CLAIM.				
				PLEASE RESUBMIT THE CLAIM WITH				
3404935	WAYNE CO MENTAL	0	0	*** NO DATA TO REPORT ***				
	HEALTH CTR				-			
	1	0	0					
	1	-	-		0	0	0	0
3404936	THE BEACON CENT	0	0	*** NO DATA TO REPORT ***				
	ER ER							
		U	U		0	0	0	0
3404937	THE BEACON CENT	8535	15	SERVICE FACILITY LOCATION WAS				
3404937	ER			NOT SUBMITTED ON THIS CLAIM.				
				PLEASE RESUBMIT THE CLAIM WITH				
		24		PROCEDURE CODE, PROCEDURE/MODI	0	18	1506	1488
				FIER COMBINATION OR PROCEDURE				
				CODE/TYPE OF SERVICE COMBINATI				
	1	3411	1	PROVIDER TYPE AND SPRCIALTY 07				
		J + ± ±	-	PROVIDER TYPE AND SPECIALTY 07 4/113 CANNOT BILL ENHANCED				
	1			BENEFIT SERVICES ON OR AFTER D				

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404939	EAST CAROLINA B	8505	1037	CLAIM DENIED DUE TO INSUFFICIE				
	EHAVIORAL H			NT BUDGET				
		0524	67	APPRILATE TRACTICATION TO N				
		8534	67	SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING	(1286	3271	1985
				PROVIDER. PLEASE VERIFY THE F				
				THOUSEN. ISSUED VENTE THE I				
		11	53	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
3404941	EAST CAROLINA B	0	0	*** NO DATA TO REPORT ***				
	EHAVIORAL H							
	mirround ii							
			1		1		1	
		0	0		(0	0	n
			1		1			
3404942	EAST CAROLINA B	0	0	*** NO DATA TO REPORT ***				
	EHAVIORAL H							
		0	0		(0	0	0
3404943	ALBEMARLE MENTA	11	46	CLIENT NOT ELIGIBLE ON SERVICE				
	L HEALTH CE			DATE				
		120	20	CLIENT ID NUMBER MISSING OR IN				
		120	20	VALID. ENTER CID AND SUBMIT		126	1758	1632
				AS A NEW CLAIM				
		191	13	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404944	EASTPOINTE HUMA	24	7	PROCEDURE CODE, PROCEDURE/MODI				
	N SERVICES			FIER COMBINATION OR PROCEDURE				
				CODE/TYPE OF SERVICE COMBINATI				
		8505	5	CLAIM DENIED DUE TO INSUFFICIE	(17	1184	1167
				NT BUDGET				
		191	2	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME	1			
3404946		8622	88	60 RESIDENTIAL LEVEL II TREATM				
	FOOTHILLS AREAM	0022	00	ENT RECEIVED, PA IS REQUIRED	1		1	
	ENTAL HEALT			FOR ADDITIONAL SERVICE.	1		-	
		-	+		1	-	-	
	1	10	31	DIAGNOSIS OR SERVICE INVALID F			1,000	1526
		1			(139	1665	1526
				OR CLIENT AGE. VERIFY CID,				
				OR CLIENT AGE. VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR				
		8599	12					
		8599	12	DIAGNOSIS, PROCEDURE CODE FOR				